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CASE NO.

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1995

COOPER TIRE & RUBBER COMPANY,
Petitioner

v.

ST. PAUL FIRE AND MARINE INSURANCE COMPANY, RICHARD C. PILLSBURY, M.D., and ROBERT MAZA
Respondents

Petition for Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

A. WHETHER FEDERAL COMMON LAW DEVELOPED UNDER ERISA SHOULD INCLUDE EQUITABLE CLAIMS BY AN EMPLOYEE BENEFIT PLAN FOR UNJUST ENRICHMENT TO PREVENT PLAN PARTICIPANTS, THIRD PARTIES AND THEIR INSURANCE COMPANIES FROM ADVERSELY AFFECTING THE PLAN'S SUBROGATION RIGHTS IN THE SETTLEMENT OF PARTICIPANTS' CLAIMS AGAINST THIRD PARTIES?

B. WHAT WEIGHT OR DEFERENCE SHOULD BE GIVEN TO THE PLAN ADMINISTRATOR'S INTERPRETATION OF THE PLAN'S RIGHTS UNDER A *FIRESTONE TIRE AND RUBBER CO. V. BRUCH* ABUSE OF DISCRETION ANALYSIS -- WHERE, AS HERE, THE COURT OF APPEALS GAVE NO WEIGHT OR DEFERENCE TO THE PLAN'S DETERMINATION THAT GENERAL SUBROGATION RIGHTS LANGUAGE IN THE PLAN INSTRUMENT ENTITLED IT TO REQUIRE PARTICIPANTS TO SIGN SEPARATE, MORE SPECIFIC SUBROGATION CONTRACTS WHICH IT DEEMED REASONABLY NECESSARY TO FACILITATE ENFORCEMENT OF ITS RIGHTS?

C. MAY A COURT OF APPEALS CONDUCT FOR THE FIRST TIME ON APPEAL A *FIRESTONE TIRE AND RUBBER CO. V. BRUCH* ABUSE OF DISCRETION ANALYSIS ON ERISA PLAN INTERPRETATION ISSUES INVOLVING PLAN SUBROGATION RIGHTS WHERE THE ISSUES WERE NEITHER RAISED IN THE DISTRICT COURT NOR RAISED, BRIEFED OR ARGUED ON APPEAL AND DOING SO REQUIRES IT TO MAKE FURTHER FINDINGS OF FACT ON AN INCOMPLETE RECORD BELOW?

PARTIES TO THE PROCEEDING

The Appellants in The United States Court of Appeals for the Eighth Circuit were Robert Maza, Dr. Richard C. Pillsbury, and Dr. Pillsbury's medical malpractice insurance carrier, St. Paul Fire and Marine Insurance Company.

Appellee in the Court below and Petitoner herein is Cooper Tire & Rubber Company ("Cooper"). Cooper has no parent corporations. It has the following subsidiaries:

ALGA Investments Company
Cooper International Holding Corporation
Cooper International Rubber, Limited
Cooper Tire International Trading Company
Coopermex, S.A. DE C.V.
North American Rubber, Incorporated
Rio Grande Servaas S.A. DE C.V.

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Petition for Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

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PETITION FOR WRIT OF CERTIORARI

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Petitioner Cooper Tire & Rubber Company ("Cooper") respectfully petitions this Court for a writ of certiorari to review a decision of the United States Court of Appeals for the Eighth Circuit.

OPINIONS BELOW

The opinion of the Eighth Circuit Court of Appeals dated February 27, 1995 is officially reported at 48 F.3d 365 and is

reproduced in the Appendix ("A") at 1-20.[1] The decision of the U.S. District Court for the Western District of Arkansas dated October 1, 1993 and its amended judgment dated April 12, 1994, from which the appeal to the Eighth Circuit was taken, are reproduced at A. 23-49; 50-64. These opinions are not published.

JURISDICTION

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254(l)(1988).

STATUTES INVOLVED

The case involves the Employee Retirement Income Security Act of 1974 ("ERISA") 88 Stat. 829 as amended, 29 U.S.C. §§ 1000 et seq. The relevant text of ERISA is reproduced at A. 65 through 66.

STATEMENT OF THE CASE

A. Introduction. This case concerns the ability of a self-funded ERISA employee benefit plan to enforce its subrogation rights. Contrary to Cooper's ERISA Plan and related agreements signed by him, Respondent, Robert Maza, settled a medical malpractice lawsuit against Respondent Dr. Pillsbury, and his insurer, Respondent St. Paul, without Cooper's written permission and without payment of Cooper's subrogated interest. Cooper filed

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[1]The Eighth Circuit's Order dated April 25, 1995 denying Cooper's Petition for Rehearing and Suggestion for Rehearing En Banc is located at A. 21. The Eighth Circuit Order dated May 2, 1995 ordering a "technical correction" to its Opinion of February 27, 1995, is reproduced at A. 22.

suit in the United States District Court for the Western District of Arkansas in its capacity as a provider of medical benefits under an employee welfare benefit plan under 29 U.S.C. §1002, asserting jurisdiction under 29 U.S.C. §1132 and 28 U.S.C. §1331.

B. Cooper's Employee Benefit Plan. Cooper is an Ohio-based manufacturer with facilities in Ohio, Indiana, Arkansas, Mississippi and Georgia. Cooper provides medical benefits to its salaried employees under an ERISA employee benefit plan, which is both administered and funded by Cooper (the "Plan"). Pertinent provisions are reproduced in the Appendix (A. 67-86A). Article 5.2 of the Plan gives the administrator the power "to construe and interpret the provisions of the Plan." (A. 78.)

C. Cooper's Subrogation Rights And Payment Of Medical Expenses. Article 12(e) of the Plan (A. 86A) provides, in part, that by accepting benefits under the Plan, employees and their dependents "agree to furnish such information and assistance, and execute such assignment and other instruments as the Company may reasonably request to facilitate enforcement of the successor rights of the Company." Article 12(e) also provides that (1) if an employee or a dependent is entitled to recover all or a portion of the benefits provided by the Plan, then "the Company will succeed to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person", with certain exceptions that are not applicable here; and (2) "[e]mployees and their dependents shall take no action prejudicing such rights of the Company."

Respondent Maza is a college-educated supervisor at Cooper and a participant in Cooper's Employee Benefit Plan. While under the care of Respondent Dr. Pillsbury, Maza's wife suffered a cardiac arrest resulting in massive brain damage. She

remained comatose until her death on September 4, 1988.

Cooper paid medical expenses under the Plan on behalf of Maza and his wife in the amount of $298,118.07. Prior to payment of these expenses, Maza signed two separate "Receipt and Subrogation Agreements" on October 13, 1988 and January 18, 1990 (A. 100-101). These agreements were executed pursuant to paragraph 12(e) of the Plan which requires the execution of assignments or other instruments reasonably required by Cooper to facilitate the enforcement of its rights. In both Receipt and Subrogation Agreements, Maza agreed to subrogate to Cooper all of his claims and "authorizes the said Cooper Tire & Rubber company to sue, compromise or settle...all such claims". Maza also agreed that he would not make a settlement or give a release "without the written consent of the said Cooper Tire & Rubber Company."

D. Maza's Settlement Of The Malpractice Action. After the death of his wife, Robert Maza filed a malpractice action against Dr. Pillsbury in an Arkansas state court. Dr. Pillsbury's malpractice carrier was Respondent, St. Paul. Cooper intervened in the action, asserting its subrogation rights to the extent of the medical payments made by Cooper. Cooper alleged that it was entitled to a first and paramount lien on any "settlement, judgment or recovery made or rendered by, for or on behalf of" Maza, an allegation admitted by Maza and denied by Pillsbury.

During the course of the state court proceeding, all parties engaged in settlement discussions during which Cooper's lawyer told counsel for St. Paul and Dr. Pillsbury that it was unethical and improper to settle around Cooper's subrogation claims. On September 12, 1990, St. Paul offered Cooper $50,000.00 to settle its $300,000.00 subrogation claim. Cooper rejected this offer on

October 10, 1990. On October 15, 1990, St. Paul and Dr. Pillsbury settled separately with Maza for $350,000.00. It is undisputed that Cooper's written consent was never requested nor given with respect to this settlement. (District Court opinion at p. 9, A. 34).

E. U.S. District Court Decision Awarding Restitution To Cooper. Cooper filed an action in U.S. District Court for the Western District of Arkansas on May 8, 1991 against St. Paul, Dr. Pillsbury and Maza seeking to recover from them the amount it paid on behalf of the Mazas -- $298,118.07. After a bench trial on September 14, 1993, the District Court entered a judgment on October 1, 1993 in favor of Cooper (A. 23-49).

In its decision, the District Court found that "It does not appear to be disputed that plaintiff's claims are governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, *et. seq.*" (A. 32). The District Court's decision relied upon an ERISA-based federal common law theory of unjust enrichment recognized by the United States Court of Appeals for the Fourth Circuit in *Provident Life & Acci. Ins. Co. v. Waller*, 906 F.2d 985, 993 (4th Cir. 1990), *cert. denied*, 498 U.S. 982 (1990), stating (A. 32):

> Where federal case law does not deal with a dispute arising under a given issue, the Court must develop federal common law, and will look to the plan contract itself, the statutory policies of ERISA and state law.

Maza and St. Paul claimed that their settlement agreement purported to "preserve" Cooper Tire's subrogation rights. The District Court disagreed and found that they had violated Cooper's rights under the subrogation agreement:

> In the Settlement Agreement, defendants expressly reserved Cooper Tire's subrogation rights *and other rights*. One of those "other rights" contained in the Subrogation Agreement was the right to effectively block a settlement by Maza by withholding written consent of same. Maza's act of settling without first obtaining the written consent of Cooper Tire concerning the settlement adversely affected Cooper Tire's "other rights".
>
> One of the purposes in obtaining subrogation rights is to insure that when an individual plaintiff who has been injured receives his money from the alleged tortfeasor, the insurer - in this case Cooper Tire - which has paid out its money quickly, will also be reimbursed quickly and will not have to spend large quantities of money and time pursuing litigation in its own behalf at a later time. . . .
>
> * * *
>
> If the Court were to approve and sanction the type of settlement reached which disregards these other valuable rights, the resulting precedent would permit an injured employee to disregard his obligations under the ERISA plan and under the Receipt and Subrogation agreements and recover for his own benefit, subjecting the ERISA plan

> administrator to the whim of attorneys for the insured and tortfeasor to determine whether the Plan's rights are adequately protected. It would also require a Plan administrator to seek recovery by separate suit against the tortfeasor. Such a ruling not only would condone a breach of contract, but would also have the potential of adversely affecting the efficient and proper administration of the ERISA plan...[S]uch a precedent would place the plan administrator in a position of paying for the medical bills quickly but not being able to be reimbursed quickly, and would further deprive the administrator of the considerable benefit of having the injured employee act as the party plaintiff in a trial against the tortfeasor. (*See* A. 36-40.)[2]

The principal defense advanced by Defendants in the District Court was that Cooper's conduct during the settlement negotiations had estopped it from objecting to the settlement notwithstanding the fact that Cooper received no notice of the settlement hearing in the state court and would have attended had it received notice [Dist. Ct. Op. A.33]. The Court rejected the estoppel defense and found that it was pre-empted under ERISA. On April 10, 1994 the District Court issued a supplemental order denying Cooper's request for attorneys fees and granting it prejudgment interest in the amount of $53,661.25. (A.51-63 at 63).

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[2]The latter portion of the excerpt quoted above was reemphasized by the District Court in its Supplemental Order of April 12, 1994 when it denied St. Paul's Motion for a New Trial (A. at 53).

F. Court Of Appeals Decision Reversing District Court. On appeal, the U.S. Court of Appeals for the Eighth Circuit reversed the District Court decision on two grounds neither raised in the lower court nor raised, briefed or argued by the parties on appeal. First, the Court criticized the District Court and the parties for "underestimat[ing] the impact of ERISA on Cooper Tire's claims" and held that "the broad pre-emptive sweep of ERISA limits Cooper Tire to the civil remedies contained in 29 U.S.C. §1132(a)", thus rejecting the federal common law basis of the District Court's decision (*See* A. 10). Second, the Court ruled that Cooper's interpretation of its subrogation rights under the Plan constituted an abuse of discretion. It did so on the basis that, contrary to Plan language, Cooper's separate subrogation contract gave it rights to all of a participant's third party claims, (but the Court conceded that the subrogation contract "can be reasonably read to apply only to claims involving medical expenses."). Candidly admitting that it made its ruling on a "limited record", the Court of Appeals also made and relied on a factual determination that "Cooper Tire has interpreted the subrogation provision inconsistently" (but the Court also conceded that "Cooper Tire's interpretation does not render any of the plan language itself internally inconsistent"). Based on these new findings of fact and law, the Court held Cooper's method of enforcing its subrogation rights to be contrary to the Plan language and an abuse of discretion. (A. 15):

> Cooper Tire may not demand written consent prior to settlement of non-medical expense claims and characterize it as a means to "facilitate enforcement" of its subrogation rights. (A. 16)

Cooper filed a Petition for Rehearing by the Panel and Suggestion for Rehearing En Banc on March 25, 1995, which was

denied on April 25, 1995 (although Judge McMillan would have granted a rehearing en banc) (*See* A. 21).

REASONS FOR GRANTING THE WRIT

I. FEDERAL COMMON LAW UNDER ERISA SHOULD INCLUDE EQUITABLE CLAIMS FOR UNJUST ENRICHMENT BY AN EMPLOYEE BENEFIT PLAN TO PREVENT PLAN PARTICIPANTS, THIRD PARTIES AND THEIR INSURERS FROM ADVERSELY AFFECTING THE PLAN'S SUBROGATION RIGHTS IN THE SETTLEMENT OF PARTICIPANTS' CLAIMS.

A. The Question Presented Is One Of Broad And Immediate Public Importance.

Millions of Americans participate in self-funded insurance plans like the one that Cooper provides to its employees. Subrogation/reimbursement provisions like the one contained in Cooper's Plan (often called "Acts of Third Parties" provisions) are found in the overwhelming majority of health care plans. Although the specific language contained in the subrogation reimbursement provision will vary from plan to plan, the plan purpose to be served by such subrogation provision is self-evident -- if the injuries for which the plan has advanced benefits are the responsibility of a third party, the plan will receive restitution of the funds it has advanced. Such restitution benefits both present and future beneficiaries of the plan by preserving assets of the plan, thus furthering one of the primary goals of ERISA. Such provisions also immediately benefit the participant who has been injured as the result of an act of a third party -- his medical costs are paid immediately without concern for the uncertainty as to

when and if those costs will be paid by the responsible third party -- thus serving another primary goal of ERISA in providing benefits to employees.

As Cooper said in its Petition for Rehearing and as the number of cases involving reimbursement/subrogation provisions and health care plans reflect, participants in health care plans, third parties responsible for their injuries, and third party insurers have attempted in a myriad of ways to avoid the impact of reimbursement subrogation provisions contained in health care plans.[3] The reason that the insurance company and plan

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[3]Rather than seeking a declaratory judgment as to the effect of the reimbursement subrogation provision *before* settling with a third party tortfeasor and its insurer, as was done in *Cutting v. Jerome Foods, Inc.* 993 F.2d 1293 (7th Cir. 1993) most participants, like Maza, attempt to settle around the plan's claims, thereby causing the plan to incur the expense associated with bringing its own cause of action for restitution, or at least the reported decisions would so reflect. *See, e.g., Pacificare, Inc. v. Martin*, 34 F.3d 834 (9th Cir. 1994); *Provident Life & Acc. Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990); *Electro-Mechanical Corp. v. Ogam*, 820 F. Supp. 346 (E.D. Tenn. 1992) *affirmed* 9 F.3d 445 (6th Cir. 1993); *Health Cost Controls v. Manetas*, Case No. 94-C-00419, 1995 U.S. District LEXIS 1800 (N.D. Ill. 1995) (A. 123-139). Other than *Jerome Foods*, there are very few cases in which plan participants actually sought a declaratory judgment concerning their rights or obligations under a subrogation reimbursement agreement. Unlike *Jerome Foods*, these cases generally arose when health care plans refused to make further medical payments because of the participants' previously settling with a third party tortfeasor without complying with their obligations under the reimbursement subrogation provision. *See, e.g., Marianjoy Rehabilitation Ctr. v. Mirtl*, 1994 U.S. Dist. LEXIS 6320 (N.D. Ill. 1994) (A. 158-173); *Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 1995 U.S. App. LEXIS 15096 (7th Cir. 1995) (A. 102-122); [fn. cont.]

participants attempt to settle around the health care plans subrogation provisions are self-evident. Participants who have already received the benefit of the funds advanced by the health care plan would like to keep as much of any settlement with the third party's insurer for their own personal use as possible without having to pay anything back to the health care plan. Third parties and their insurers likewise have a monetary motive in enabling the participant to avoid his subrogation and reimbursement obligation -- they can settle more cheaply with the participant if all of the settlement goes to the participant personally than if they had to include the sums advanced by the health care plan in the settlement. The District Court recognized this in its opinion in this case:

> The Court is of the opinion that Pillsbury and St. Paul knew at all times that, if they could settle their claim with Maza, they could reduce the settlement value of the claim with Cooper Tire....Cooper Tire has been stripped of its right to be associated with Maza in connection with the settlement and of its right to expect that when Maza gets his money, Cooper Tire will get its money.

Singleton v. Board of Trustees of IBEW Local 613, 830 F.Supp. 630 (N.D. Ga. 1993). But *see, MacIntosh v. Pacific Holding Company*, 992 F.2d 882 (8th Cir. 1993) (plan participant settled her claim and designated them as noneconomic damages in the settlement agreement in an unsuccessful attempt to avoid application of the subrogation provision. She placed the settlement sum in escrow pending resolution of a declaratory judgment action concerning the health care plan's subrogation rights to the settlement.)

See Dist. Ct. Op. A. 44-45.

Cooper submits that this Court should recognize the existence of a federal common law claim under ERISA by an employee benefit plan for restitution based on unjust enrichment whenever a third party is responsible for the injuries for which a plan has advanced expenses conditioned upon a right of reimbursement or subrogation. Failure to do so would have a major impact on self-funded health plans who would be without remedy to recover substantial sums of money advanced for a participant's medical costs when the injuries that occasion those costs are the responsibility of a third party. Companies will either have to reduce health benefits or charge higher out-of-pocket costs for its participants in the forms of co-payments and deductibles. Or, companies may simply draft provisions in their plans that totally exclude claims that may be the responsibility of a third party until after third party liability is established, thereby depriving participants of an important benefit, i.e. the right to have their medical costs immediately paid, even if a third party may ultimately be liable for the injuries.

Constant litigation over the validity and enforceability of reimbursement litigation provisions, even in those cases in which the Courts have enforced the subrogation agreements signed by the employee, adds to the cost of administering health care plans.[4]

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[4]Indeed, in August, 1993, the court in *Singleton v. Board of Trustees of IBEW Local 613, supra*, noted that "the argument that an injured individual covered by an ERISA plan should not have to reimburse the plan for settlement amounts received for pain and suffering apparently has been rejected by every court that has faced it." *See* 830 F.Supp. at 631. This is no longer true as the Eighth Circuit's decision in this case and the Ninth Circuit's in *Pacificare, Inc. v. Martin*, *supra*, reflect.

Recognizing a plan's federal common law claim under ERISA for restitution based on unjust enrichment should significantly reduce such litigation, thus furthering ERISA's goal of preserving plan assets and lowering administrative costs. Participants will know that they must reimburse the health care plan for advanced medical costs without regard to potential attacks on the enforceability of specific reimbursement subrogation agreements.

B. A Conflict Exists Among The Circuits With Respect To A Plan's Federal Common Law Claim Under ERISA For Restitution Based On Unjust Enrichment.

A conflict exists among the Circuits as to whether the courts have the power under ERISA to fashion a federal common law remedy for restitution based on unjust enrichment. The division among the circuits is likely to become even greater than the conflict that presently exists as district courts have also divided on this issue not only among the circuits, but within the circuits themselves. The Fourth Circuit has explicitly recognized a federal common law claim for unjust enrichment under ERISA even in the absence of a signed subrogation agreement when the plan contains a subrogation provision. *See Provident Life & Acci. Ins. Co. v. Waller*, 906 Fd.2d 985, 993 (4th Cir.) *cert. denied* 498 U.S. 982 112 Led.2d 524 (1990). The Ninth Circuit has explicitly rejected the holding of the Fourth Circuit in *Provident* and has refused to recognize a federal common law cause of action for unjust enrichment even where a subrogation agreement has been signed. *See Pacificare, Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994).

Most District Courts of other circuits which have considered this issue have held that a federal common law action under ERISA will lie for unjust enrichment in this type of case.

See, e.g., Travitz v. Northeast Dept. ILGWU H & W Fund, 818 F.Supp. 761 (M.D. Pa. 1993) *affirmed* 13 F.3d 704 (3rd Cir.) *cert. denied* _____ U.S. ____, 128 L.Ed.2d 888 (1994) (Third Circuit did not consider *Provident* issue because not timely raised on appeal); *Pople v. Cox*, 1993 U.S. District LEXIS 16105 (N.D. Ill.) (A. 174-183); *Health Cost Controls v. Manetas*, 1994 U.S. District LEXIS 2505 (N.D. Ill. 1994) (A. 123-139); *Harris Trust and Savings Bank v. Provident Life & Acc. Ins. Co.*, 854 F.Supp. 524 (N.D. Ill. 1994); *Hercules, Inc. v. Pages*, 814 F.Supp. 79 (M.D. Fla. 1993). *But see Hedberg v. Zaldivar*, 1994 U.S. District LEXIS 2505 (N.D. Ill. 1994) (A. 150-157). The majority of these decisions have not been appealed (or the issue was not raised before the Circuit Court) and, therefore, the other Circuit Courts of Appeals have not been in a position to rule upon them. The Seventh Circuit, however, has expressed sympathy for the Fourth Circuit's *Provident* view. *See, e.g., Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 1995 U.S. App. LEXIS 15096 (7th Cir. 1995) (A. 102-122). In the instant case, however, the Eighth Circuit Court of Appeals has implicitly endorsed the minority view expressed by the Ninth Circuit in *Pacificare*.

The District Court in *Provident* had refused to allow the plan to recover its advanced expenses because of its failure to obtain a signed repayment agreement as referenced in the plan document. On appeal, the Fourth Circuit determined that it had the power to fashion a federal common law remedy of unjust enrichment in order to fill in the "interstices of ERISA", and held that Provident had a claim for reimbursement of the advanced medical expenses under a federal common law cause of action for unjust enrichment. The Fourth Circuit set forth three factors in fashioning such a remedy, "[W]e look to the plan contract itself, the statutory policies of ERISA, and state law. (citations omitted)"

The Circuit Court in *Provident* noted first that the contract specifically provided for repayment of the advanced monies. "Thus, the creation of a common law remedy here would *further* the contract between the parties and effectuate the clear intent of Provident's 'acts of third parties' clause." As to the second factor, the Fourth Circuit then determined that the unjust enrichment remedy was in accord with the statutory provision in ERISA that allows for the return of mistakenly paid contributions made by employees to multi-employer plan funds. Noting that several courts had created common law remedies for employers to recover erroneous payments to pension funds because failure to recognize such a cause of action "could lead to severely inequitable results that we do not believe were intended by Congress," the Court further stated:

> [a]lthough the payment made by Provident was probably not mistakenly advanced, §1103(c)(2)(A) indicates a desire to ensure that plan funds are administered equitably and that no one party, not even plan beneficiaries, should unjustly profit." 906 F.2d 993.

Finally, the Fourth Circuit Court found that the facts of the *Provident* case presented the "archetypal unjust enrichment scenario".

The Ninth Circuit, despite its rejection of the *Provident v. Waller* doctrine, did not disagree with the Fourth Circuit's reasoning that an unjust enrichment remedy furthers the purposes of ERISA. Rather, the Ninth Circuit's holding was based solely upon its belief that it had no authority to create federal common laws causes of action under ERISA. The Court then, with no further analysis concerning the merits of the common law unjust

enrichment claim, simply held that *Pacificare*'s federal common law cause of action was not one of the specific remedies listed in 29 U.S.C. §1132 and therefore did not state a permissible cause of action under ERISA. 34 F.3d at 836.

The District Court in the present case, citing *Provident*, implicitly grounded its finding in favor of Cooper on the federal common law of unjust enrichment, "Where federal case law does not deal with the dispute arising under a given issue, the court must develop federal common law, and will look to the plan contract itself, the statutory policies of ERISA and state law." *See* p. 7 of Dist. Ct. Op. (A. 32.)

On appeal in the instant case, the Eighth Circuit overlooked the fact that the District Court had explicitly based its decision on the federal common law as set forth in *Provident*[5] and, like the Ninth Circuit's decision in *Pacificare*, held that any claim by Cooper "must be based on a specific ERISA provision. The broad preemptive sweep of ERISA limits Cooper Tire to the civil remedies contained in 29 U.S.C. §1132(a)."

The facts in the instant case are remarkably similar to those in *Provident* with one exception -- the employee participant in *Provident* was not asked to and did not sign a reimbursement agreement, despite the plan provision requiring her to do so; Maza did. Both cases, however, involve an employee participant who has benefited from receiving monies advanced from the ERISA plan, thereafter settling with the third party tortfeasor, then trying to avoid repaying the plan the monies advanced.

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[5]Instead, the Eighth Circuit mischaracterized the District Court's decision as one based upon state common law rather than federal common law. *See* p. 13 of Court of Appeals Opinion A.17.

Dr. Pillsbury and St. Paul have also been unjustly enriched and the District Court had no difficulty explaining the benefits unjustly received by Dr. Pillsbury and St. Paul, i.e., drastically impairing Cooper's settlement leverage.

> It should be obvious that of the two (2) claims -- that of Maza as a bereaved widower, who lost his wife allegedly as a result of alleged medical malpractice of one of the defendants, as opposed to the claim of Cooper Tire, a large business entity who is simply seeking reimbursement for dollars paid out -- the former is by far more attractive to a jury and more potentially dangerous to defendants than is the latter. It would logically follow, therefore, that if not settling the latter claim would prohibit the favorable settlement of the former claim, defendants would be more likely to settle the latter claim than they would if it were the only claim the defendants would have to consider.

Cooper submits that the Fourth Circuit's decision in *Provident* and the District Court's decision in this case based upon *Provident* are correct -- Cooper does have a right for restitution of its monies advanced to Maza based on federal common law under ERISA. By granting this Petition, the Court can correct the conflict posed by the Eighth and Ninth Circuits' failure to recognize this right.

II. COURTS OF APPEALS SHOULD DEFER BROADLY UNDER A *FIRESTONE TIRE AND RUBBER CO. V. BRUCH* ABUSE OF DISCRETION ANALYSIS TO A PLAN ADMINISTRATOR'S REASONABLE INTERPRETATION AND ENFORCEMENT OF THE PLAN'S SUBROGATION RIGHTS .

A. The Question Presented Is One Of Broad And Immediate Public Importance.

Faced with the question of the appropriate review standard for interpretation by plan administrators, this Court in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989) held that the "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine the terms of the plan." 489 U.S. at 115. When an administrator is given discretionary authority to interpret the terms of the plan, *Firestone* held that the interpretation is reviewed under an arbitrary and capricious or abuse of discretion standard. But in doing so, what weight or deference is to be given to the administrator's interpretation? *Firestone* does not offer sufficient guidance on this issue because application of that standard has been subject to conflicting decisions by the Courts of Appeals.

Two distinct, opposing viewpoints have emerged from the tests developed by the Circuits: (1) the view that the courts should defer broadly, although not totally, to the interpretation given by the administrator; and (2) multi-part tests which give little or no weight or deference to the administrator's interpretation. These contradictory analyses applied by the Courts of Appeals fail to provide the uniformity demanded by ERISA. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (ERISA intended to

provide uniform set of rules for benefit plans).

As this case demonstrates, the result is that administrators' decisions on almost identical facts are deferred to in one circuit and found to be arbitrary and capricious in another. This question begs for further clarification by this Court.

B. There Is A Conflict Among The Circuits Regarding The Interpretation Of Subrogation Rights Which Illustrates The Wider Conflict Among The Circuits As To The Weight Or Deference To Be Given To Plan Interpretations.

A comparison of the present decision by the Eighth Circuit with a case by the Seventh Circuit involving almost identical facts illustrates the conflict between the Circuits over the deference to be given to the interpretation of the administrator.

The Seventh Circuit in *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993), held that requiring the employee to sign a separate subrogation agreement very much like Cooper's pursuant to a plan provision, again very much like Cooper's, was not an abuse of discretion. As in the present case, the plan contained a subrogation clause which provided that by accepting benefits the employee and his dependents agreed the plan was subrogated "to all claims, demands, actions, and rights of recovery of the individual or any insurer, including Worker's Compensation, to the extent of any and all payments made hereunder by the Plan." The employee and his dependent refused to sign a separate agreement agreeing to reimburse the plan from any amounts that they received from other sources. Rejecting the beneficiary's contention that federal common law should adopt a "make whole" rule that would preclude recovery until the

beneficiary recovers all other damages, Judge Posner, writing the opinion for the Seventh Circuit, upheld the interpretation given by the administrator and held that the company did not interpret the subrogation provisions of the plan unreasonably by requiring the separate subrogation agreement.

In reaching its decision, the court specifically deferred to the interpretation given by the administrator, "If the plan itself vests discretion in the administrator -- if as here it gives the administrator a long leash -- the courts pull back and defer broadly although not totally to the administration's determination, upending it only if persuaded that the administrator acted unreasonably" 993 F.2d at 1296. *See also Saracco v. Local Union 786 Pension Fund*, 942 F.2d 1213 (7th Cir. 1991) (court can overturn the decision only if an abuse of discretion, "which is to say that the decision was not just clearly incorrect, but downright unreasonable").

On the other hand, the Eighth Circuit in the present case held that Cooper's requirement of an almost identical Receipt and Subrogation Agreement was a violation of the arbitrary and capricious standard. To reach this conclusion, the Eighth Circuit disdained the Seventh Circuit's "long leash" and used a five-part analysis first announced in *De Nobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989)[6] which only plays lip service to the arbitrary and capricious standard by stating that the interpretation of the administrator would be upheld if reasonable. The five factors used to determine reasonableness are (1) whether the interpretation is consistent with the goals of the plan; (2) whether the interpretation renders any language in the plan meaningless or internally inconsistent; (3) whether the interpretation conflicts with the

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[6] *See also Finley v. Special Agents Mutual Benefit Assn.*, 957 F.2d 617 (8th Cir. 1992) (adopting the five-part test of *De Nobel*).

substantive or procedural requirements of the ERISA statute; (4) whether the words at issue have been interpreted consistently; and (5) whether the interpretation is contrary to the clear language of the plan.

As applied by the Eighth Circuit in this case, the Court gave no deference -- let alone broad deference -- to Cooper's interpretation of its subrogation rights despite the Court's finding that (1) Cooper's interpretation was consistent with the goals of the Plan; (2) its interpretation did not render any language in the plan meaningless or internally inconsistent; and (3) the separate subrogation contracts "can be reasonably read" not to contradict the plan language. These findings would have upheld Cooper's interpretation even under the "clearly incorrect" let alone the "downright unreasonable" standard of the Seventh Circuit.

Instead, the Eighth Circuit's application of the five-part test is indistinguishable from a *Firestone de novo* review, i.e., "looking to the terms of the plan and other manifestations of the parties' intent". *Firestone* at 113. This is evidenced by the Eighth Circuit's additional findings of fact regarding (1) Cooper's alleged "inconsistency" in interpreting its rights inconsistently (based on a single 13 year old letter sent to Maza regarding subrogation in 1980)[7] and (2) the alleged failure of its Summary Plan Description (SPD) to "even mention subrogation rights."[8]

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[7]No evidence exists that Cooper inconsistently applied the requirement of a Receipt and Subrogation Agreement to other similarly situated participants or beneficiaries.

[8]This was incorrect. Cooper's SPD states, in pertinent part, "Certain benefit payments for employees and/or dependents may have to be repaid if they are covered under the [fn. cont.]

1. *The Third, Fifth, Sixth, Ninth, Tenth and D.C. Circuits defer to the interpretation of the administrator*. Like the Seventh Circuit, the Third, Fifth, Sixth, Ninth, Tenth and D.C. Circuits all give substantial weight and deference to the Administrator's interpretation.

In *Jones v. Sonat, Inc.*, 997 F.2d 113 (5th Cir. 1993), the Fifth Circuit reviewed three factors in determining whether the decision was legally correct: (1) whether the administrator has uniformly interpreted that section of the plan in the past; (2) whether the administrator's interpretation of the plan is consistent with a fair reading of the plan; and (3) whether the interpretation results in any unanticipated costs. Hence, the Court's primary analysis focuses upon the administrator's interpretation, thereby giving the broad deference to the administrator required by the arbitrary and capricious standard. But even if legally incorrect, the Fifth Circuit will still under some circumstances defer to an administrator's decision. *See, also, Haubold v. Intermedics, Inc.* 11 F.3d 1333 (5th Cir. 1994).

The Sixth Circuit refers to an arbitrary and capricious standard that may be shaped by other factors present in the case. In *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979 (6th Cir. 1991), the court stated that an administrator's decisions on eligibility for benefits are not arbitrary and capricious if they are "rational in light of the plan's provisions." 925 F.2d at 984. In *Baker v. UMWA Health and Retirement Funds*, 929 F.2d 1140 (6th Cir. 1991), the court stated that the trustee's decision would be upheld if it is the result of a deliberate, principled reasoning

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Subrogation section of this Plan..." This fact-finding error was corrected by the Eighth Circuit after Cooper raised it in its Petition for Rehearing (*See* A. 22).

process and if it is supported by substantial evidence. 929 F.2d at 1144.

The Third, Ninth, Tenth and D.C. Circuits' approach is similar to the Sixth Circuit's and abides by the simple analysis of whether the interpretation is based upon a reasonable interpretation of the plan documents. *Abnathya v. LaRoche, Inc.*, 2 F.3d 40 (3rd Cir. 1993) (may overturn administrator's decision only if without reason, unsupported by substantial evidence, or erroneous as a matter of law); *Clark v. Washington Teamsters Welfare Trust*, 8 F.3d 1429 (9th Cir. 1993) (question is not which interpretation is correct, but whether the interpretation by the trustee is unreasonable); *Woolsey v. Marion Laboratories, Inc.*, 934 F.2d 1452 (10th Cir. 1991); *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450 (D.C. Cir. 1992) (reasonableness of the administrator's decision is the polestar).

2. *The Fourth, Eighth and Eleventh Circuits give no weight to the administrator's interpretation.* As shown previously, the test used by the Eighth Circuit is based upon a test announced by the Fourth Circuit in *De Nobel, supra*. Like the Eighth and Fourth Circuits, the Eleventh Circuit standard of review fails to give any deference to the interpretation of the administrator. Although several cases discuss and develop the standard, the definitive process is summarized in *Nightingale v. Blue Cross and Blue Shield of Alabama*, 41 F.3d 1476 (11th Cir. 1995). That decision also gives lip service to the *Firestone* requirement that the courts must use the arbitrary and capricious standard when discretion is given to the administrator. But the test used gives deference to the claimant's interpretation *not* the Administrator's. If the *claimant* has established a reasonable interpretation, then the claimant's interpretation is correct under *contra proferentum* which requires ambiguities to be construed against drafters. The court

also held that *contra proferentum* applies to self-funded plans. In a self-funded plan, the Eleventh Circuit then imposes a burden of proof on the administrator to prove that its interpretation was not tainted by self-interest.

These Circuit Court decisions as well as the Eighth Circuit's decision in *Cooper* and the Seventh Circuit's decision in *Jerome Foods* illustrate the gulf now existing between the Circuits with respect to the application of the arbitrary and capricious standard.[9] The Third, Sixth, Seventh, Ninth, Tenth and D.C. Circuits broadly defer to reasonable interpretations of the administrator. On the other hand, the five-part test of the Fourth and Eighth Circuits and the claimant deference approach of the Eleventh Circuit give little or no consideration to the interpretation of the administrator, thereby subordinating the plan's interpretation

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[9]The recent case of *Curtis-Wright Corporation v. Schoonejongen*, 63 U.S.L.W. 4201 (1995) also highlights the errors committed by the Eighth Circuit in this case. Against the contention that the language of the plan did not state the amendment procedure with sufficient specificity, *Curtis-Wright* held that the simple language that the plan may be amended "by the Company" adequately described the amendment procedures. "ERISA, rather, follows standard trust law principles in dictating only that whatever level of specificity a company ultimately chooses, *in an amendment procedure or elsewhere*, it is bound to that level." *Curtis-Wright*, 63 U.S.L.W. at 4204. Like the amendment procedure in *Curtis-Wright*, Cooper's Plan language regarding subrogation does not spell out the reasonable measures that Cooper may take to protect its interests. However, as with *Curtis-Wright*, Cooper's requirement of the Receipt and Subrogation Agreement falls squarely within the boundaries of the plan language -- even the Court of Appeals conceded it could "reasonably (be) read" this way. Its requirement was a reasonable request never questioned by any party until raised *sua sponte* by the Eighth Circuit.

to that of the court's. None of the factors utilized by the Fourth, Eighth, and Eleventh Circuits give any consideration to the broad deference afforded by the arbitrary and capricious standard and naturally undermines the very essence of the standard. Granting this petition will empower this Court with the authority to correct this conflict and to provide the uniformity mandated by ERISA.

III. A *FIRESTONE TIRE AND RUBBER CO. V. BRUCH* ABUSE OF DISCRETION ANALYSIS OF ERISA PLAN INTERPRETATION ISSUES INVOLVING PLAN SUBROGATION RIGHTS SHOULD NOT BE CONDUCTED FOR THE FIRST TIME ON APPEAL WHERE DOING SO INVOLVES MAKING FURTHER FINDINGS OF FACT ON AN ALREADY INCOMPLETE RECORD.

A. The Question Presented Is One Of Broad And Immediate Importance.

The development of a uniform body of law under ERISA requires that it be done based upon (1) a complete record developed in the District Court on issues raised, briefed and argued there and (2) careful consideration by a Court of Appeals based on issues raised, briefed and argued before it. It is too important a subject to be done by Courts of Appeals acting as "self-directed boards of legal inquiry and research" deciding legal questions not presented and argued by the parties before them. *Carducci v. Regan* 714 F.2d 171, 177 (D.C. Cir. 1983) (Scalia, J.). As first expressed by this Court in *Hormel v. Helvering*, 312 U.S. 552, 556, 85 L.Ed. 1037, 61 S.Ct. 719 (1941) and re-emphasized in *Singleton v. Wulff*, 428 U.S. 106 49 L. Ed.2d 826 96 Ct. 2868 (1976):

> It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below. In *Hormel v. Helvering*, ...the Court explained that this is "essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues...[and] in order that litigants may not be surprised on appeal by a final decision there of issues upon which they have had no opportunity to introduce evidence."

See also United States v. Burke, 504 U.S. 229, 119 L.Ed.2d 34 at 50. (Scalia, J., concurring in the judgment):

> The rule that points not argued will not be considered is more than just a prudential rule of convenience; its observance, at least in the vast majority of cases, distinguishes our adversary system of justice from the inquisitorial one.

And *Carducci v. Regan*, *supra*,

> The premise of our adversarial system is that appellate courts do not sit as self-directed boards of legal inquiry and research, but essentially as an arbitrator of legal questions presented and argued by the parties before them.

Cooper was certainly surprised on appeal by the Eighth Circuit's decision on new factual and legal "issues upon which (it) had no opportunity to introduce evidence." Cooper subsequently echoed Justice Scalia's point in its unsuccessful Petition for Rehearing:

> At a minimum, these issues deserved, but did not receive, consideration in the crucible of the adversarial process as well as the contemplative calm of appellate chambers. Because this did not happen, the Panel inadvertently overlooked still other issues and produced a decision which is contrary to both U.S. Supreme Court and Eighth Circuit precedent.

In an area like ERISA, it is vital that the Supreme Court remind circuit courts of the limits on their discretion in considering issues for the first time on appeal. Granting this Petition or simply remanding the case for further proceedings before the District Court will accomplish this.

B. The Decision Below Conflicts With Decisions Of This Court And With Decisions Of Other Courts Of Appeals.

The Court of Appeals' consideration in this case of an issue neither raised by Respondents in District Court nor raised, briefed or argued on appeal is in direct conflict with earlier decisions of this Court and of other circuits including the Eighth Circuit itself. There are only carefully limited circumstances under which a Court of Appeals may consider an issues for the first time on appeal:

> The matter of what questions may be taken up and resolved for the first time on appeal is one left primarily to the discretion of the courts of appeals, to be exercised on the facts of individual cases. We announce no general rule. Certainly there are circumstances in which a federal

> appellate court is justified in resolving an issue not passed on below, as there the proper resolution is beyond any doubt, see *Turner v. City of Memphis*, 369 U.S. 350, 7 L.Ed.2d 762, 82 S.Ct. 805 (1962), or where "injustice might otherwise result." *Hormel v. Helvering*, 312 U.S. at 557 , 85 L.Ed. 1037, 61 S.Ct. 719.

Singleton v. Wulff, supra, at 428 U.S. at 121. *See also, Kamon v. Kemper Financial* Services, 500 U.S. 90, 114 L. Ed.2d 152 (1991) at n.5.

Courts of Appeals have further developed the rule of *Singleton v. Wulff* as to when and under what limited circumstances a Court of Appeals may consider an issue for the first time on appeal. *Schmidt v. Polish Peoples' Republic*, 742 F.2d. 67, 70 (2nd Cir. 1984) ("only when necessary to avoid manifest injustice)"; *Matter of Heci Exploration Co., Inc.*, 862 F.2d 513 (5th Cir. 1988) ("We will ordinarily consider an argument raised for the first time on appeal only if it raises a purely legal issue and would require no further findings of fact."); *Brown v. Marshall*, 704 F.2d 333 (6th Cir. 1983) *cert. denied*, 464 U.S. 835, 78 F.2d 119 (1983); *Zbaraz v. Qwern*, 572 F.2d. 582 (7th Cir. 1978) ("these issues can best be resolved in the context of a record developed in a hearing in the District Court."); *Stafford v. Ford Motor Co.*, 790 F.2d 702 (8th Cir. 1986) ("A contrary rule could encourage a party to 'sandbag' at the district court level only then to play its 'ace in the hole' before the appellate court.") *Tyrone Pacific International, Inc. v. The Vessel MV Eurychili*, 658 F.2d 64 (9th Cir. 1981); *Lyons v. Jefferson Bank & Trust*, 994 F.2d 716 (10th Cir. 1993) (...a party may not lose in the District Court on one theory of the case, and then prevail on appeal on a different theory"): *United States v. Oakley*, 744 F.2d 1553, 1556 (11th Cir.

1984); *Texas Whirl Legal Aid, Inc. v. Legal Services Corp.*, 940 F.2d 685 (D.C. Circuit 1991) ("we find the absence of any substantive briefing on the issue dispositive...this Court normally will not address claims raised in such a cursory fashion.")

There is nothing in the Court of Appeals decision in this case which indicates that it ever considered the two tests suggested in *Singleton*: "the proper resolution is beyond any doubt" or "where injustice might otherwise result". Nor is there anything to indicate it considered any of the post-*Singleton* case law discussed above. Indeed, its new findings of fact on appeal clearly place it in conflict with the Fifth Circuit's test of "only if it raises a purely legal issue and would require no further findings of fact." And the new legal theories it advanced clearly conflict with the Tenth Circuit's test that "a party may not lose in the District Court on one theory...and then prevail on appeal on a different theory."

Cooper submits that *Singleton* requires a reversal of the Court of Appeals decision. Alternatively, and at a minimum, this case should simply be remanded to the District Court for a full evidentiary hearing on the record and development of the Plan interpretation issues.

CONCLUSION

For the foregoing reasons, Cooper respectfully requests that the Writ of Certiorari be granted.

Respectfully submitted,

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